



STATE OF MARYLAND

DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

MEMORANDUM

TO: PERSONAL CARE SERVICES PROGRAM COORDINATORS
AND CASE MONITORS

FROM: Mark A. Leeds, Director
Long Term Care and Community Support Services

RE: New Medical Assistance Personal Care Services Program Procedure Codes and
Billing Practices

DATE: November 14, 2003

Enclosed please find a Maryland Medical Assistance Program Memorandum describing HIPAA-related changes for the Medical Assistance Personal Care Services Program (MAPCSP). Effective January 3, 2004, the Maryland Medical Assistance Program will change the procedure codes for the MAPCSP. The billing formats for the MAPCSP will also change effective January 3, 2004. The Maryland Medical Assistance Program is making these changes to comply with the Health Insurance Portability and Accountability Act (HIPAA).

The enclosed HIPAA instructions govern only MAPCSP codes and transactions between the Local Health Department (LHD) and the Department of Health and Mental Hygiene (DHMH). LHDs may elect to use any coding and transaction method between their MAPCSP providers and the LHD. It is only the transactions between the LHDs and DHMH that must comply with the enclosed instructions.

It is the responsibility of coordinators, case monitors, and staff of each Local Health Department Personal Care Program to train their personal care providers regarding any new billing practices and procedure codes. Please forward to us any materials that you may develop to assist with training your personal care providers. If you have any questions regarding this memorandum, please contact the MAPCSP staff at 410-767-1444. Thank You.

Enclosure

cc: Mary Fox Dozier

Shauna Thompson

Toll Free 1-877-4MD-DHMH • TTY for Disabled – Maryland Relay Service 1-800-735-2258

Web Site: www.dhmh.state.md.us





STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

TO: Personal Care Services Program Coordinators/Case Monitors
FROM: Susan J. Tucker *Susan J. Tucker* Joseph E. Davis *Joe Davis*
Executive Director Executive Director
Office of Health Services Office of Operations and Eligibility
RE: HIPAA Implementation
DATE: November 14, 2003

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires health care providers to submit claims in a nationally standardized format using national procedure codes. The Department of Health and Mental Hygiene Medical Care Program (the Program) is working hard to crosswalk the codes, modify our transactions, and make the system changes necessary to pay claims under a new, HIPAA-compliant methodology.

Effective **January 3, 2004**, the Program will change the procedure codes for the Medical Assistance Personal Care Services Program (MAPCSP). More detailed instructions are below.

Additionally, effective **January 3, 2004**, Local Health Departments must utilize the following to bill the Program for MAPCSP services:

- **Electronic Transactions:** MAPCSP electronic transactions to the Program may be either the "modified" CMS-1500 format or the ASC X12N 837P Transactions. There is information below on companion guides, testing, and the trading partner agreement. If you plan to submit electronic claims using the ASC X12N 837P Transactions, either directly or through a billing service, you must return a signed Submitter Identification Form and Trading Partner Agreement. The forms are attached.
- **Paper Transactions:** All MAPCSP paper transactions must be submitted to the Maryland Medical Assistance Program on the CMS-1500 (formerly the HCFA-1500) form. The billing instructions are discussed below and example forms are attached.

The Program will implement MAPCSP transaction and code changes on January 3, 2004. You have until January 2, 2004 at 4:00 pm to submit claims in the current format. Until January 3, MAPCSP should continue billing the Program as they do now.

If you have any questions regarding this memorandum, please contact the MAPCSP staff at 410-767-1444.

PROCEDURE CODE CHANGES

Effective January 3, 2004

MAPCSP Procedure Code Change		
Current Code	Code for dates of service on or after 1/3/2004	Service
H0100	Z0100	DAY OF PERSONAL CARE (AGENCY)
H0101	Z0101	DAY OF PERSONAL CARE
H0102	Z0102	DAY OF TRAINING FOR PERSONAL CARE
H0062	END	LEVEL 2 PERSONAL CARE (AGENCY) - AM VISIT
H0063	END	LEVEL 2 PERSONAL CARE (AGENCY) - PM VISIT
H0072	Z0072	LEVEL 2 PERSONAL CARE - AM VISIT
H0073	Z0073	LEVEL 2 PERSONAL CARE - PM VISIT
H0082	Z0082	DAY OF PERSONAL CARE (AGENCY) - LEVEL 2
H0092	Z0092	DAY OF PERSONAL CARE - LEVEL 2
H0083	Z0083	DAY OF PERSONAL CARE (AGENCY) - LEVEL 3
H0093	Z0093	DAY OF PERSONAL CARE - LEVEL 3
H0041	END	DAY OF LEVEL 4 PERSONAL CARE SHIFT 1
H0042	END	DAY OF LEVEL 4 PERSONAL CARE SHIFT 2
H0043	END	DAY OF LEVEL 4 PERSONAL CARE SHIFT 3
H0044	END	MONTH OF LEVEL 4 CASE MONITORING
H0105	Z0105	MONTH OF CASE MONITORING (AGENCY)

For claims with a Date of Service before January 3, 2004, use the “H” codes. For claims with a Date of Service on or after January 3, 2004, use the “Z” codes.

Example#1 – A provider submits a claim in February 2004 for services rendered on November 28, 2003. This claim must be submitted on either the paper CMS-1500 or the “modified CMS-1500”/electronic X12N 837P using the “H” procedure code.

Example#2 – A provider submits a claim in February 2004 for services rendered on January 15, 2004. This claim must be submitted on either the paper CMS-1500 or the “modified CMS-1500”/electronic X12N 837P using the “Z” procedure code.

The Program will not pay any claims with the “H” codes for dates of service on or after January 3, 2004.

The Program will not pay any claims using the DHMH 248 or the old electronic billing systems on or after January 3, 2004.

BILLING TRANSACTION CHANGES

Effective January 3, 2004

Electronic Transactions (Electronic Claims)

On and after January 3, 2004, all electronic transactions for MAPCSP must be submitted as either the "modified CMS-1500" or ASC X12N 837P Transactions. Please consult your Information Technology staff or billing software vendor.

Companion Guides

In working toward the January 3, 2004 implementation deadline, the Program produced Companion Guides to assist providers for the ANSI ASC X12N Transactions. The X12 837 and X12 835 Companion Guides can be obtained through the DHMH website at: <http://www.dhmh.state.md.us/hipaa/transandcodesets.html>.

Testing

Providers who plan to send electronic transmissions directly to the Program must test for HIPAA compliance before they can transmit claims to us for payment. The Program offers free testing, which can be accessed at: <http://www.dhmh.state.md.us/hipaa/testinstruct.html>.

Trading Partner Agreement and Submitter Identification Form

If you are billing using the X12N 837 P:

The Local Health Department's MAPCSP must complete and return ONE Trading Partner Agreement and ONE Submitter Identification Form. You do not have to fill out a separate form for each provider. We have attached a copy of our Trading Partner Agreement and Submitter Identification Form to this memo.

Additionally, the Program requires a list of providers for whom the Local Health Department MAPCSP submits claims. For your convenience, we have attached a list of providers that are currently in our billing system. Please verify that these are your providers (cross off any providers that are no longer participating in the program) and return the edited list with the Submitter Identification Form.

The Program must have both the Trading Partner Agreement and Submitter Identification Form on file before accepting any HIPAA transactions including X12N 837 (Claims). Each form has a contact phone number if you have additional questions or if you are unclear which forms you are to fill out.

Mail completed forms to:

Rita Tate
201 W. Preston St. Rm. LL3
Baltimore MD 21201
Attn: HIPAA Billing Agreements

If you are billing on the "Modified CMS-1500":

The Trading Partner Agreement and Submitter Identification Form are not necessary.

Paper Transactions (Paper Claims)

On and after January 3, 2004, all paper claims must be submitted on the CMS-1500 form.

Paper Billing Instructions

The Program accepts both red-and-white and black-and-white paper CMS-1500 forms. The red-and-white versions may be purchased at most office supply stores. The black-and-white version may be downloaded from <http://cms.hhs.gov/providers/edi/cms1500.pdf>. The State will not supply these forms.

Basic Rules for the Paper CMS-1500:

- On and after January 3, 2004, use the CMS-1500.
- Use one CMS-1500 for each recipient.
- Be sure that the information entered on the form is legible.
- Double-check all information on the claim, especially the Provider and Recipient Numbers.
- Enter information with a typewriter or in black ink.
- Only six dates of service can be billed on one CMS-1500 form. If you need to bill additional dates, you must complete a new CMS-1500 form with all the required information completed.
- Paper CMS-1500 claims should be mailed to:
Office of Operations & Eligibility
State Department of Health and Mental Hygiene
P.O. Box 1935
Baltimore, Maryland 21203

THERE ARE ONLY 11 FIELDS THAT MUST BE COMPLETED!

(Block numbers that are not described below may be left blank.)

MAPCSP Provider CMS-1500 Paper Billing Instructions		
Block Number	Title	Action
2	Patient's Name	Enter the patient's last and first name from the Medicaid Identification Card.
9a	Other Insured's Policy or Group Number	Enter the patient's 11-digit MA number as it appears on the MA card. The patient's MA eligibility should be verified on each date of service prior to rendering service by calling the Eligibility Verification System (EVS).
11	Insured's Policy Group or FECA Number	Enter "K". This indicates that Personal Care is not covered by any other insurance.

Medical Assistance Personal Care Services Program Coordinators/Case Monitors

24 A	Date(s) of Service	Enter each separate date of service as a six digit numeric date (e.g. 06/01/04) under the "From" heading. Leave the space under the "To" heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates <u>ARE NOT</u> accepted on this form.
24 B	Place of Service	Enter "12".
24 D	Procedures, Services or Supplies	Enter the procedure code under the space labeled "CPT/HCPCS". For dates of service on or after January 3, 2004, use the "Z" procedure codes.
24 F	\$ Charges	Enter the usual and customary charge.
24 G	Days or Units	Enter "1".
28	Total Charge	Enter the sum of the charges shown on all lines of Block 24 F.
31	Signature of Provider and Date	The provider's signature is required. The claim date <u>MUST</u> be in this field in order for the claim to be reimbursed.
33	Physician's Suppliers Billing Name, Address, ZIP code & Phone #	The MA provider number to which payment is to be made <u>MUST</u> be entered in the lower right corner of this block to the <u>IMMEDIATE RIGHT OF THE WORDS "GRP#"</u> . Your claim will not be reimbursed if there is an error in this number or if it is omitted.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

Example #1

HEALTH INSURANCE CLAIM FORM									
PICA					PICA				
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Jackson, Joseph E.					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()					4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ()				
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER 12345678900 b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE				
11. INSURED'S POLICY GROUP OR FECA NUMBER K a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____					14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN				
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. RESERVED FOR LOCAL USE				
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____				
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER				
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE									
11 28 03 12 H0092 20 00 1									
11 29 03 12 H0092 20 00 1									
11 30 03 12 H0092 20 00 1									
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.				
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 60 00				
29. AMOUNT PAID \$					30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jane Smith 2/10/04 SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					PIN# GRP# 009876543				

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Example #2

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

CARRIER